Citation: Smith v. Intact Insurance, 2024 ONLAT 21-015217/AABS

Licence Appeal Tribunal File Number: 21-015217/AABS

In the matter of an application pursuant to subsection 280(2) of the *Insurance Act*, RSO 1990, c I.8, in relation to statutory accident benefits.

Between:

Moreen Smith

Applicant

and

Intact Insurance

Respondent

DECISION

VICE-CHAIR: **Terry Hunter**

APPEARANCES:

For the Applicant: Gordon W Harris, Counsel

For the Respondent: Sonya Katrycz, Counsel

HEARD: **In Writing**

OVERVIEW

[1] The applicant was injured in an automobile accident on November 10, 2017 and sought benefits from the respondent pursuant to O. Reg. 34/10: Statutory Accident Benefits Schedule – Effective September 1, 2010 (the "*Schedule").* The respondent refused to pay for certain benefits and the applicant has applied to the Licence Appeal Tribunal – Automobile Accident Benefits Service (the "Tribunal") for resolution of this dispute.

[2] On the day of the accident the applicant was the sole occupant of her vehicle which was travelling northbound when it was struck from behind by another vehicle travelling around 80 km/h.

[3] Two days after the accident the applicant went to the hospital and was diagnosed with spinal strain. The applicant went to her family doctor, Dr. Norrie, on November 17, 2017 and reported accident related pain. The applicant was removed from the MIG on April 4, 2020. The applicant has a significant pre-accident medical history including chronic pain, degenerative disc disease, back pain, anxiety and depression.

MOTION/PRELIMINARY ISSUE

[4] Following the case conference and prior to the hearing the respondent filed a motion to have the following preliminary issue added to the hearing.

i. Is the applicant statute barred from proceeding with the LAT application in its entirety or some of the issues in dispute as a result of the applicant's failure to attend an insurer's examination pursuant to sections 44 and 55 of the *Schedule?*

[5] The respondent submits that the applicant failed to attend IEs scheduled to assess her entitlement on ACBs initially on February 3 and February 5, 2020 and then on February 20, 2020 and March 5, 2020. I agree. In her submissions, the applicant did not dispute that she failed to attend the IEs in question. In fact, the applicant agreed in her reply submissions that she would attend a new set of IEs if the respondent provided her with new Notices of Examination. With no evidence to the contrary and based on the applicant's own submissions, I grant the respondent's motion and find that the applicant failed to attend IEs pursuant to sections 44 and 55 of the *Schedule*.

[6] In addition, and/or in the alternative, I also find, for the reasons listed below, that the applicant has failed to establish entitlement to any of the substantive benefits in dispute.

ISSUES

[7] The issues in dispute to be determined at the hearing are:

i. Is the applicant entitled to attendant care benefits (ACBs) proposed by Sherry Kettyle, as follows.

   (a) $1,105.68 per month from November 10, 2017 to May 1, 2019?

   (b) $319.85 per month from May 1, 2019 to date and ongoing?

ii. Is the applicant entitled to $2,000.00 for a psychological assessment from Dr. S. Jett submitted November 20, 2019 and denied December 19, 2019?

iii. Is the applicant entitled to $4,720.00 for a neurological assessment from Dr. M. Rathbone, submitted June 13, 2020 and denied June 24, 2020?

iv. Is the applicant entitled to psychological services from Apex Health Network, as follows:

   (a) $698.28 for psychological treatments, submitted June 16, 2020 and partially denied on October 29, 2020?

   (b) $1,247.51 for psychological treatments, submitted September 15, 2020 and partially denied on December 4, 2020?

   (c) $1,200.00 for a psychological reassessment, submitted November 1, 2021 and denied November 17, 2021?

v. Is the applicant entitled to $2,941.57 for a chronic pain assessment from the Michael G. DeGroote Pain Clinic, submitted January 26, 2021 and denied April 12, 2021?

vi. Is the applicant entitled to $2,170.00 for physiotherapy treatments from South City Physiotherapy submitted on December 03, 2019 and denied December 12, 2019?

vii. Is the applicant entitled to $1,627.79 for physiotherapy treatments from Francine Dore, submitted February 5, 2021 and denied February 22, 2021?

viii. Is the applicant entitled to $87.19 for a concussion assessment from Dr. S. Meldrum, submitted December 20, 2019 and denied May 27, 2020?

ix. Is the respondent liable to pay an award under s. 10 of O. Reg. 664 because it unreasonably withheld or delayed payments to the applicant?

x. Is the applicant entitled to interest on any overdue payment of benefits?

RESULT

[8] I find that the applicant is not entitled to any of the disputed benefits, nor interest or an award.

ANALYSIS

The Applicant did not "incur" ACBs

[9] The applicant claims entitlement to ACBs at the rate of $1,105.68 per month from November 10, 2017 to May 1, 2019 and at the rate of $319.85 per month ongoing from May 1, 2019.

[10] Section 3(7) (e) of the *Schedule* lays out what requirements the applicant needs to meet for ACBS to be deemed "incurred". At the hearing the applicant provided no evidence that she "incurred" any attendant care expenses following the accident. The applicant did not submit any receipts or invoices of services provided, nor did she identify or name anyone who provided attendant care services to her. Based on the complete lack of evidence submitted by the applicant, I find that the applicant has failed to demonstrate that she has any entitlement to ACBs.

[11] In her submissions the applicant refers to section 3(8) of the *Schedule* which permits, me to "deem" these expenses to have been incurred if the respondent unreasonably withheld or delayed the payment of benefits.

[12] I am not persuaded by the applicant's argument that I should deem the expenses "incurred" because the respondent initially put the applicant in the MIG. This is not a logical explanation or rational for the applicant's failure to never have "incurred" the benefit. Even if the applicant did not have the funds to pay for

ACBs services, which she did not assert, section 3(7)e *Schedule* extends to a promise to pay the expense.

[13] The applicant did not submit a Form 1 to the respondent until two years post accident. Despite being in the MIG at the time, the respondent scheduled two sets of insurer's examinations to have the applicant assessed for her entitlement to ACBs. I find that the respondent's adjusting of the applicant's claim for ACBs was reasonable and therefore have no reason to deem the benefits to have been incurred.

[14] Since, I have found that the applicant has failed to establish that she incurred any ACBs there is no need for me to consider under section 19 of the *Schedule* if the applicant required the services of an aide or attendant because of the injuries she sustained in the accident.

Treatment and Assessments

[15] Sections 14 and 15 of the *Schedule* provide that an insurer is only liable to pay for medical expenses that are reasonable and necessary as a result of the accident. The applicant bears the onus of proving on a balance of probabilities that any proposed treatment or assessment plan is reasonable and necessary.[1]

Psychological Treatment and Assessments

[16] At issue is whether the psychological assessment recommended by Dr. S. Jett and the psychological treatment and re-assessment recommended by Apex Health Network are reasonable and necessary.

[17] The applicant submits that her pre-existing psychological conditions made her vulnerable and were exacerbated post-accident. The applicant's submissions direct me to the December 2, 2020 report of Dr, Jacobs, a doctor who specializes in chronic pain, as evidence to support her claim. The applicant also argued that psychological treatment was reasonable and necessary to enable her to perform her activities of daily living.

[18] The two treatment plans for psychological services which are in dispute were both partially approved by the respondent. In its submissions the respondent confirms that the $698.28 which is dispute relates to an OCF-18 in the amount of $2,989.06, listed above as issue iv (a). The respondent approved $2,200.00 for the psychological assessment and related documentation but denied four sessions of psychotherapy. The denial of the four sessions was based on a s.44

[1] *Scarlett v. Belair,* 2015 ONSC 3635

assessment of Dr. Bradley who opinioned these sessions were pre-mature. The respondent argues that these sessions represent a duplication of services because, it subsequently approved a s. 25 psychological assessment conducted by Dr. Mpumlwana and the psychotherapy treatment that was recommended in that assessment.

[19] I agree with the respondent and find it was pre-mature to approve four sessions of psychotherapy before the psychological assessment was completed by Dr. Mpumlwana. Because the applicant received psychotherapy following Dr. Mpumlwana's assessment, it would be a duplication of services and hence not reasonable and necessary for the applicant to attend the four disputed session now.

[20] My finding is supported by the report of Dr. Ratti, psychologist, dated July 27, 2021, who conducted a section 44 psychological assessment after the applicant completed the psychotherapy session that were recommended and supervised by Dr. Mpumlwana. Dr. Ratti found that the applicant was not manifesting any diagnosable psychological problems on the DSM. In his addendum report, Dr. Ratti, opined that no further psychological treatment was reasonable and necessary.

[21] The other issue in dispute, listed above as issue iv(b), relates to an OCF-18 in the amount of $3,431.20 for psychotherapy services to be provided by Catherine Roach and supervised by Dr. Mpumlwana. The denied portion of the treatment plan in the amount of $1,247.51, relates to the hourly rate charged by Catherine Roach which exceeded the hourly rate payable under the Professional Services Guidelines.

[22] The applicant made no submissions and adduced no evidence in relation to the Professional Service Guidelines which are at the crux of this dispute. Due to the lack of submissions and/or evidence adduced by the applicant on this issue, I was unable to find that the applicant is entitled to the disputed amount of $1,247.51.

[23] In terms of the psychological assessment (issue ii) and re-assessment (issue iv (c), the respondent argues, that these are duplicative services that have already been provided, and therefore are not reasonable and necessary. I agree.

[24] The applicant has failed to persuade me that these assessments are reasonable and necessary. In her submissions, the applicant fails to mention or address the fact that Dr. Mpumlwana conducted a section 25 psychological assessment on August 28, 2020 that was approved and paid for by the respondent. As noted

above, the respondent also approved a treatment plan for psychotherapy sessions which were supervised by Dr. Mpumlwana.

[25] The applicant's submissions failed to address why another psychological assessment and a re-assessment are reasonable and necessary. The applicant directed me to the report of Dr. Jacob as evidence of her entitlement to additional psychological assessments.

[26] In his report Dr. Jacob, does not make a psychological diagnosis, nor does he refer to the assessment conducted by Dr. Mpumlwana or opine on why additional psychological assessments are reasonable and necessary. I therefore find that the applicant has failed to discharge the burden of establishing her entitlement to the psychological assessment and re-assessment recommended by Apex Health Network.

[27] I am also not persuaded by the applicant's argument that she requires additional psychological assessments to perform her activities of daily living. According to the CNRs of Dr. Norrie, the applicant family doctor, the applicant was quite active after the accident. In 2018 the applicant reported she was running and was going out with friends one night a week to go to band practice. In 2019. she travelled to Australia. The CNRs of South City Physiotherapy confirm that the applicant reported she was gardening more in 2021 and did tons of painting at her friend's house with minimal pain in June 2021. The applicant consistently reported to assessors, such as Dr. Rathbone and Dr. Kumbhare, that she returned to her part-time jobs, working as a financial advisor and a first aid instructor, several months after the accident, and had continued to work albeit at a reportedly slower and/or reduced rate. Based on her reported level of post-accident functioning, I reject the applicant's argument that the disputed psychological assessments are reasonable and necessary for her to perform her activities of daily living.

Neurological Assessment

[28] The applicant claims she is entitled to $4,720.00 for a neurological assessment from Dr. M. Rathbone, submitted on June 13, 2020.

[29] The applicant argues she is entitled to the neurological assessment because it has been incurred despite the treatment plan being denied. She also argues that the fact the respondent requested a section 44 assessment with a neurologist to assess her entitlement to this benefit is evidence that it is reasonable and necessary. Finally, the applicant directs me to the report of Dr. Rathbone, who

conducted the assessment, to establish that the assessment was reasonable and necessary.

[30] The respondent makes several arguments and points out that cost of the assessment is beyond the $2,000.00 maximum allowed under section 25 of the *Schedule*. The respondent submits that the assessment is not reasonable and necessary because the applicant could have been assessed by Dr. Lad, an OHIP-funded neurologist who treated her prior to the accident. Also, the respondent argues that because Dr. Rathbone only diagnosed the applicant with a "sub-concussive injury" as opposed to a concussion that the assessment itself was not reasonable and necessary.

[31] I reject the applicant's argument that because she incurred the expense, that I should find it reasonable and necessary. It was a personal choice of the applicant to proceed with the assessment and it does not constitute a ground upon which I can find the assessment to be reasonable and necessary.

[32] I reject the respondent's argument with regards to Dr. Lad. I do however find, based on the CNRs of Dr. Norrie that if he believed that a neurological assessment was reasonable and necessary because of injuries sustained in the accident, he would have referred the applicant for one. In 2016 when the applicant complained of headaches, Dr. Norrie referred the applicant to a neurologist. An MRI was conducted, and several numerological consults followed. It was ultimately determined that the growth in the applicant's brain was benign and not responsible for her headaches. As the applicant's treating physician, I find Dr. Norrie was in the best position to determine if the applicant required a neurological assessment following the accident. Dr. Norrie, however, did not do so. I therefore find, on balance, that the neurological assessment, in dispute, is not reasonable and necessary.

[33] My finding is supported by the fact that on April 16, 2019, Dr. Norrie completed a form for the Ministry of Transportation indicating that the applicant did not suffer from any injuries to her head.

[34] I note that in his report Dr. Rathbone does not make any reference to the applicant's pre-accident consults with neurologists, including with Dr. Lad, or to the applicant's pre-accident MRI. Due to these significant oversights and to his diagnosis of a sub-concussive injury, I put little weight on Dr. Rathbone's report and am unable to find that it is reasonable and necessary.

Chronic Pain Assessment

[35] At issue is an OCF-18 for a chronic pain assessment (Issue v, which in error is identified in the case conference order as a multi-disciplinary assessment), submitted by Michael G. DeGroote Pain Clinic on January 26, 2021 in the amount of $2,941.57.

[36] The applicant argues that this assessment is reasonable and necessary because she struggles with ongoing chronic pain and psychological issues which are well documented in her family doctor's records and were identified by both Dr. Jacobs and Dr. Rathbone.

[37] I find that the applicant has failed to establish that this assessment is reasonable and necessary because of injuries sustained in the accident. It is undisputed that the applicant suffered from chronic pain prior to the accident and had received treatment at the Jacobs Pain Clinic. Dr. Norrie's CNRs confirm that the month before the accident, he was considering referring the applicant tor an assessment for chronic pain.

[38] The respondent argues, and I agree that the applicant made no complaints of pain related to the accident to Dr. Norrie from her first post-accident visit until January 2021. Due to the applicant's lack of reference to accident-related pain to her family doctor for such a significant period, and her ability to return to work and perform other activities of daily living including such as working, I find insufficient evidence that a chronic pain assessment was warranted in 2021 because of the applicant's accident-related injuries.

[39] I do note that in January 2021, Dr. Norrie referred the applicant for a chronic pain assessment with the Jacobs Pain Clinic, and that his notes refer to "chronic pain from mva years ago". However, due to the applicant's lack of reference to the accident until January of 2021, I find on balance that this reference was a result of the applicant's self-reporting rather than a clinical opinion based on causation.

Physiotherapy treatments

[40] At issue is the applicant's entitlement to physiotherapy treatments recommended by South City Physiotherapy in December 2019 and February 2021.

[41] The applicant submits she is entitled to this treatment because physiotherapy will increase her strength, reduce her pain, and increase her ability to return to normal activities of daily living. In her submissions the applicant points me to the

report of Dr. Kumbhare dated October 12, 2022 to support her need for physiotherapy.

[42] The respondent argues based on the s. 44 assessments conducted by Dr. Khaled, medical doctor, that the disputed treatment plans are not reasonable and necessary. Dr. Khaled assessed the applicant twice in person and authored two reports dated January 31, 2018 and December 20, 2019, and also produced two paper reviews. Based on his assessment of the applicant, Dr. Khaled found that the applicant sustained uncomplicated soft-tissue injuries in the accident and that further treatment for these injuries was not reasonable and necessary.

[43] I accept and put more weight on the findings of Dr. Khaled than those of Dr. Kumbhare. Dr. Khaled's 2019 assessment of the applicant was conducted contemporaneous with the disputed treatment plans and are therefore more reliable in terms of what the applicant's condition was at that point in time.

[44] I also find that Dr. Khaled's evidence more reliable than Dr. Kumbhare's. Dr. Kumbhare states in his report that the applicant had been unable to return to running and participate in social activities. This however contradicts the information contained in Dr. Norrie's CNRs and those of South City Physiotherapy, which state that the applicant participated in both. Dr. Kumbhare also recommends additional treatment such as physiotherapy despite acknowledging the applicant has no reduction in performing her activities of daily living.

[45] Based on my acceptance of Dr. Khaled's reports, I find the applicant is not entitled to the treatment plans in question because she has failed to establish that they are reasonable and necessary.

Concussion Assessment

[46] The applicant claims she is entitled to $87.19 for a concussion assessment from Dr. S. Meldrum, submitted December 20, 2019. This amount was denied by the respondent because the hourly amount claimed was above the maximum allowed under the Professional Services Guidelines.

[47] Applicant argues that the full amount of the treatment plan has been incurred and should be paid.

[48] The respondent argues and I agree, that the applicant made no submissions and submitted no evidence as to why this amount should be paid considering the reason for the respondent's denial. Based on the applicant's lack evidence and

submissions I find that the applicant has failed to establish that she is entitled to the disputed amount of $87.19.

Interest

[49] Interest applies on the payment of any overdue benefits pursuant to s. 51 of the *Schedule.* The applicant is not entitled to interest because I have found that she is not entitled to any of the benefits in dispute.

Award

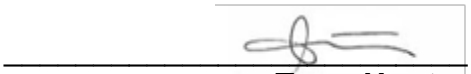
[50] The applicant sought an award under s. 10 of Reg. 664. Under s. 10, the Tribunal may grant an award of up to 50 per cent of the total benefits payable if it finds that an insurer unreasonably withheld or delayed the payment of benefits. I find no reason to grant an award because the applicant has been unable to establish that the respondent unreasonably withheld or delayed the payment of any benefits she is entitled to.

Conclusion

[51] The applicant is not entitled to any of the benefits in dispute.

[52] The applicant is not entitled to interest or costs.

Released: January 19, 2024



Terry Hunter
Vice-Chair